CHAPTER VI

ASSISTED LIVING SCREENING INFORMATION

CHAPTER VI
TABLE OF CONTENTS

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ASSESSMENT AND AUTHORIZATION FOR ASSISTED LIVING SERVICES

Services will be offered only to individuals who have been certified as eligible for assisted living services by an assessor. The assessor will evaluate the individual's functional and medical needs and authorize services to meet those needs. Payment for assisted living services is only available for recipients residing in a department of social services licensed assisted living facility that has a valid DMAS provider agreement. The assessor must notify the appropriate LDSS eligibility staff upon completion of the UAI that the recipient has been authorized for assisted living and must forward the UAI and authorization forms to DMAS, the assisted living facility chosen by the recipient, and to the case manager, if case management services have been authorized. The assessor must give all recipients who have been denied assisted living services written notification that services have been denied and give the recipient the right to appeal the decision.

Definition of Assessment

An assessment is a standardized approach using common definitions to gather sufficient information on applicants to and residents of ALFs to determine their care needs, and, for Auxiliary Grant and General Relief recipients, to determine their need for residential care. Assessment is the prior authorizing mechanism for public reimbursement for ALF services.

Since July 1, 1994, most publicly funded human service agencies in Virginia, including the local departments of social services, area agencies on aging, community services boards, centers for independent living, state facility staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and Medicaid Nursing Home Pre-Admission Screening Committees have been using one common assessment, the UAI, to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring resident care needs ALF across agencies and services. The UAI is comprised of a short assessment, designed to be an intake/screening document and a full assessment, designed to be a comprehensive evaluation. The completion of the short or full UAI is based on the initial review of the individual's needs and which long-term care service has been requested. A training manual entitled *User's Manual: Virginia Uniform Assessment Instrument* provides thorough instructions regarding completion of the assessment (a copy of this manual is available from DMAS. Please visit the DMAS website at www.dmas.virginia.gov for more information).

Assessment of ALF applicants and residents is a process to:

1. Evaluate the medical, nursing, developmental, psychological, and social needs of each individual seeking ALF admission and continued placement;

2. Analyze what specific services the individual needs; and

3. Determine the level of care required by the individual by applying the criteria for ALF care.

The assessment of the availability of ALF services depends upon:

1. Whether an ALF licensed to meet the needs of the individual exists in the community;

2. Whether financial eligibility can be established; and

3. Whether the ALF states that it can meet the individual's needs.

Assessors for Auxiliary Grant or General Relief (Public Pay) Individuals

An assessor will provide initial assessments and authorization for assisted living services. An assessor may be a case manager employed by a public human service facility or other qualified assessor who has a contract with DMAS to complete the assessment for residents of ALFs. The assessor will notify the recipient, the ALF, DMAS, and the eligibility worker in the local department of social services of the results of the assessment. Auxiliary Grant and General Relief residents will also receive annual reassessments, and Auxiliary Grant residents may receive targeted case management services from the case managers employed by the public human service agencies. Assessments must be completed by the assessor whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care.

For public pay individuals, assessors include the following:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards;
- Local departments of health;
- State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services;
- Acute care hospitals; or
- An independent physician contracting with DMAS to complete the UAI for ALF applicants and residents.

Assessments: Who Must Be Assessed?

- ALL residents of and applicants to ALFs must be assessed, regardless of payment source or length of stay.

- New admissions to ALFs must be assessed prior to admission.

Assessments: What Is to Be Completed for Public Pay?

- Short UAI assessment (first 4 pages of the UAI) and medication administration (page 5) and behavior pattern (page 8) for residential clients.
- Full UAI assessment for all assisted living clients.

Assessments: Who Pays for Assessments?

For public pay residents of ALFs, DMAS will reimburse assessors $25 for a short assessment and $100 for a full assessment. DMAS also will reimburse $25 for the 12-month short assessment and $75 for the 12-month full assessment.

Assessments: When to Complete the UAI

1. An assessor must complete the UAI within 90 days prior to the date of admission to the ALF. No one can be admitted to an ALF without having been assessed except in the case of a documented emergency placement. A Virginia adult protective services worker or case manager for public-pay individuals must document and approve emergency placement.

2. The UAI must be completed or updated by an assessor at least once every 12 months on all ALF residents. The twelve-month reassessment is based upon the date of the last assessment (e.g., original assessment, twelve-month reassessment, or assessment for change in level of care) and does not need to be performed in the same month as the financial eligibility redetermination which is performed by the LDSS in the locality in which the individual resided prior to ALF placement. The financial eligibility worker must have documentation in the eligibility record that there is a current assessment on file (a current assessment is one that is not older than 12 months). The ALF must coordinate with the assessor to determine that the annual reassessment is completed as required.

3. The UAI must be completed or updated as needed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care.

The full assessment must be completed for any recipient who receives assisted living services.

Assessment Agency Responsibilities

Each assessment agency is responsible for completing the following tasks:

- To determine if the individual to be assessed is already Auxiliary Grant or General Relief or has made application to the appropriate LDSS for an Auxiliary Grant or General Relief;

- To complete the assessment process within two weeks of referral;
- To determine the appropriate level of care, determine that the individual has no prohibited conditions, and authorize service on the Medicaid Long-Term Care Pre-Admission Screening Authorization (DMAS-96);
- To contact the ALF of the individual's choice. (Determine if the ALF license matches the individual authorization and can meet the individual's needs.);
- To submit the paperwork to all entities as directed;
- To refer the individual for psychiatric/psychological examination, if appropriate; and
- To plan for the required 12-month reassessment (make referrals if appropriate);

New Assessments Not Needed: Current Assessment Completed within 12 Months (and No Change in Level of Care)

- **Lapse in financial eligibility:** If a resident becomes ineligible for an Auxiliary Grant based on income or countable resources, the LDSS eligibility worker will issue a notice of adverse action to the recipient 10 days in advance of the action to terminate the Auxiliary Grant. However, if the resident becomes financially eligible again, a new UAI will not be needed if the current UAI is less than 12 months old.
- **Transfer from one ALF to another ALF:** When an individual residing in an ALF transfers to another ALF in the Commonwealth, he or she is not required to be reassessed at the time of the transfer unless there has been a significant change in the person's condition that would warrant a change in level of care. The ALF from which the individual is transferring must send a copy of the most current UAI and Long-Term Care Authorization form (DMAS-96) to the receiving facility and notify the individual's assessor. The assessor is responsible for ensuring that the appropriate local eligibility worker receives notice of the transfer. The receiving ALF then must initiate the appropriate documentation and submit it to DMAS for admission certification purposes.
- **Admitted to a hospital from an ALF:** When the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge, a new UAI is not needed. If an individual is admitted from an ALF and the individual needs to transfer to Medicaid-funded community-based care, an assessment must be completed according to the nursing home pre-admission screening policies and procedures. If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, an assessment is not required. The second ALF must get the necessary documentation (UAI and DMAS-96) from the initial facility, complete an individualized service plan,

and submit the required paperwork to DMAS.

- **Individuals assessed and awaiting ALF placement:** At times, an individual who has been assessed as appropriate for ALF care will have to remain in the community while waiting for an ALF bed. Once a placement becomes available, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the resident's condition. If more than 90 days have elapsed, a new assessment will be required.

Changes in Level of Care Assessments

Changes in level of care can be completed by all entities qualified to perform initial assessments. The change in level of care assessment must be conducted within two weeks of receipt of the request for assessment when a permanent change in level of care is indicated, including when the resident presents with one or more of the prohibited conditions as described in this chapter. Temporary changes in an individual's condition that can be reasonably expected to last less than 30 days do not require a new assessment or update. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, and a well established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

When a level of care for a public pay resident has changed as documented on the UAI, the assessor must immediately notify the financial eligibility worker of the date of the assessment. If there is a change in level of care, and the ALF is licensed for the new level, then the ALF would receive payment for the new level of care based on the effective date of authorization on the Long-Term Care Pre-Admission Screening Authorization (DMAS-96). In order to receive this payment, the ALF must submit a copy of the new DMAS-96 (completed by the assessor) and the ISP (completed by the ALF) to DMAS as required by the admission certification procedures.

Other Special Assessment Factors

- **Private Pay Conversion to Auxiliary Grant recipient --** When a private pay resident becomes an Auxiliary Grant recipient, the LDSS eligibility worker will advise the resident of program requirements. All assessment procedures must be followed. The LDSS eligibility worker must be provided with a copy of the Long-Term Care Pre-Admission Screening Authorization (DMAS-96) for verification of the assessment. If there is a "public pay" UAI assessment completed by a public pay assessor on record that is less than 12 months old, the resident does not need to be reassessed unless there is an indication that his or her level of care has changed. The alternate private pay version of the UAI cannot be used to meet the assessment requirement.

- **Independent assessments --** At the request of the ALF, the resident's representative, the resident's physician, VDSS, or the local department of social services, an independent assessment using the UAI can be completed to determine whether the

resident's care needs are being met in the current placement. An independent assessment is an assessment that is completed by an entity other than the original assessor; this may be another assessor within the same agency. The ALF must assist the resident in obtaining the independent assessment as requested.

- **Out-of-state individuals --** Individuals who reside out of state and wish admission to Virginia ALFs must be assessed and authorized prior to public reimbursement for these services. When an out-of-state individual seeks ALF placement in Virginia, the LDSS or other public human service assessor in the locality of the ALF accepts the application for an Auxiliary Grant and completes the assessment. Information may be obtained by telephone interview if a face-to-face interview is not practical, with a follow-up on-site visit within seven days after the admission.

- **Emergency placements --** In emergency placements, the UAI must be completed within seven working days from the date of placement. An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. Prior to the placement, the need for an emergency placement must be documented and approved by a Virginia adult protective services (APS) worker or case manager for public pay individuals. This is the **only** instance in which an individual may be placed in an ALF without first having been assessed to determine if he or she meets ALF level of care. Once the individual has been placed, assessments and case management procedures must be followed. An appropriate assessor in the jurisdiction must complete the assessment where the individual lived prior to the emergency placement.

- **Individuals discharged from an ALF to Medicaid-funded nursing home or home and community-based care services:** The Pre-Admission Screening (PAS) Committee in the locality of the ALF is responsible for assessment and authorization for individuals who are ALF residents and who may need nursing home or personal care services. The ALF will schedule with the PAS Committee to complete a screening for any individual whose needs can no longer be met in the assisted living facility. The PAS Committee handles this referral as it would a referral coming from anywhere else in the community. If the individual is in the hospital, the hospital PAS Committee can complete the assessment and authorization process for other Medicaid-funded long-term care services.

TARGETED CASE MANAGEMENT:

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or
2. Ongoing targeted ALF case management.

It is believed that most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment and not ongoing targeted case management services.

Who Can Provide Medicaid-Funded ALF Case Management?

To qualify as a provider of case management, the provider of services must ensure that all case management staff meet minimum qualifications. The case manager must possess a combination of work experience and relevant education, which indicates that the individual possesses the knowledge, skills, and abilities related to the provision of assessment and case management services. Medicaid-funded case management services for Auxiliary Grant
ALF residents can be provided by:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards; and
- Local departments of health.

Twelve-Month Reassessment:

The purpose of the twelve-month reassessment is the re-evaluation of service need and utilization review. The assessor shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. The outcome of this review shall be communicated to the LDSS eligibility staff, DMAS, the facility where the resident resides, and the resident. All ALF residents must be reassessed at least annually. All applicants for an Auxiliary Grant must have an assessment completed before Auxiliary Grant payment can be issued.

The twelve-month reassessment is completed by the assessor conducting the initial assessment. If the original assessor is neither willing nor able to complete the assessment and another assessor is not available, or if the individual moves, then the local department of social services where the resident resides, following placement in an ALF, is the assessor (except for residents receiving Medicaid-funded mental health or mental retardation case management services).

When initial assessments are completed by acute-care hospital staff, state facility staff, or a physician who may be a qualified assessor, but who will not have twelve-month reassessment or case management responsibilities, the assessor completing the initial assessment must refer these responsibilities to another assessor as soon as possible, but no later than one month prior to the due date of the twelve-month reassessment.

If the resident is receiving targeted case management services for mental illness or mental retardation, the case manager for this service must complete the reassessment as part of the case management responsibilities for that individual.

Ongoing Medicaid-Funded Targeted ALF Case Management Services:

Ongoing Medicaid-funded targeted ALF case management is a service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the assessor must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The case manager for ongoing-targeted ALF case management is responsible for:

1. The completion of the UAI, either short assessment or full assessment, as appropriate (the twelve-month reassessment is considered one of the quarterly contacts);
2. Any change in level of care, as appropriate;
3. Developing the plan of care that addresses needs on the UAI (which cannot be met by the ALF) and maintaining the log of contacts;
4. Implementing and monitoring the plan of care, including arranging, coordinating, and monitoring services;
5. Monitoring the ALF's Individualized Service Plan (which addresses needs that are set by licensing standards) for the resident and other written communications concerning the care needs of the resident;
6. A quarterly visit with the resident or his or her representative to evaluate the resident's condition, service needs, appropriate service placement, and satisfaction with care;
7. Serving as the contact for the ALF, family, MEDALLION PCP, the MCO case manager, and other service providers to coordinate and problem solve; and
8. Assistance with discharge, as necessary.

Medicaid-funded ongoing-targeted case management services are not available to General Relief residents because these residents are not Medicaid eligible.

Acute care hospitals, state mental health/mental retardation facilities, and private physicians may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments only.

Reimbursement for targeted case management services is paid quarterly. The reimbursement rate for this service is $75.00 per quarter. The reimbursement for the annual reassessment is covered through the $75.00 quarterly reimbursement and the providers will not receive any additional reimbursement for this function.

DMAS-FUNDED SERVICES IN ALFS

In general, the criteria for assessing an individual's eligibility for public payment for ALF care and services consist of the following:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living (ADLs) or instrumental activities of daily living (IADLs);

2. Medication administration; and

3. Behavior pattern/orientation.

To qualify for public payment for ALF care, an individual must meet the criteria described below and also in Appendix B.

Criteria for Residential Living **(Included for reference only as this is not a Medicaid program. ALFs do not submit paperwork to DMAS for these residents.)**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating or feeding, or both) (page 4 of the UAI);

2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of the UAI); or

3. Rated dependent in medication administration (page 5 of the UAI).

Auxiliary Grant-eligible recipients residing in ALFs on February 1, 1996, may remain in the facility even though they currently do not meet the residential living criteria.

Criteria for Regular Assisted Living

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs (page 4 of the UAI); or

2. Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of the UAI).

PROHIBITED CONDITIONS

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor must document that they are present on the UAI, and the Auxiliary Grant or General Relief recipient or applicant is not eligible for ALF placement. State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs (**bold text is used to indicate language from the law**):

1. **Ventilator dependency:** A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.

2. **Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing and care is provided by a licensed health care professional under a physician's treatment plan:** Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The following is a summary of dermal ulcer stages:

   Stage I A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved;

   Stage II A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater;

   Stage III A full thickness of skin loss, exposing the subcutaneous tissues (presents as a deep crater with or without undermining adjacent tissue); and

   Stage IV A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

3. **Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia:** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks.

   Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein: Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parental nutrition (TPN). Intermittent intravenous therapy may be provided for a limited period

of time on a daily or periodic basis by a licensed health care professional under a physician's treatment plan.

4. **Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**

5. **Psychotropic medications without appropriate diagnosis and treatment plans:** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotics, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Dalmane, Valium, Thorazine, Librium, Tranxene, Ativan, Xanax, Vistaril, Atarax, Restoril, Amytal, Mellaril, Haldol, and Clozaril.

6. **Nasogastric tubes:** A nasogastric tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.

7. **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube:** Gastric tube feeding is the use of any tube that delivers food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).

8. **Individuals presenting an imminent physical threat or danger to self or others:** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the resident.

9. **Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day):** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Residents requiring continuous licensed nursing care may include:

    a. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or

    b. Individuals with a health care condition with a high potential for medical instability.

10. **Individuals whose physician certifies that placement is no longer appropriate**.

11. **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the *State Plan for Medical Assistance* -- Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.**

12. **Individuals whose health care needs cannot be met in the specific ALF as determined by the residence**.

The ALF must plan for the discharge of any resident who has a prohibited condition.

AUTHORITY FOR AUTHORIZATION OF DMAS PAYMENT

After the assessor has completed an assessment and established a level of care, the assessor is responsible for authorizing the appropriate services. During the authorization process, the assessor, with input from the individual being assessed, will decide: what services, if any, are needed; who will provide the services; and the setting where services will be provided. The assessor will identify the available community services and make referrals as appropriate. The appropriate level of care must be documented on the Long-Term Care Pre-Admission Screening Authorization (DMAS-96).

Assessors have the responsibility and authority for authorizing DMAS reimbursement for ALF services. In those instances when the assessment documentation does not **clearly** indicate that the individual meets ALF criteria, DMAS funding for these services cannot be authorized. Any information needed to support the assessor's level-of-care decision must be documented on the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement and thus can overturn any decision made by the assessor. Any authorization made by the assessor is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the service provider initiates contact with the individual.

The possible results from ALF assessment may include:

1. A recommendation for ALF care;

2. Referral to a Pre-Admission Screening Committee to review whether the individual is appropriate for Medicaid-funded community-based care or nursing home care;

3. Referrals to other community resources (non-Medicaid-funded) such as home health services, adult day care centers, home-delivered meals, etc.; or

4. Referral for services not required.

ACTIONS TO BE TAKEN UPON COMPLETION OF THE ASSESSMENT

Prior to placement in an ALF, the assessor contacts the ALF to discuss the level of care needed and to ensure that the ALF has the appropriate licensing and is enrolled as a Medicaid provider. The assessor must also discuss with the ALF staff the types of services needed by the applicant and determine whether the ALF is capable of providing the required services or whether they are available in the community.

When care of a resident's special medical needs is provided by licensed staff of a home-care agency, the ALF staff may receive training from the home-care agency staff in appropriate treatment monitoring techniques regarding safety precautions and emergency actions. If a public pay resident has special needs that can be provided by a home health agency, DMAS may reimburse for these services after a review to determine if the services fall within DMAS' guidelines for home health services. Recipients with a prohibited condition cannot stay in an ALF, and DMAS will not reimburse for home health services in this case.

Once the placement is finalized, the assessor notifies the LDSS financial eligibility worker responsible for determining the Auxiliary Grant payment of the effective date of admission using the Long-Term Care Pre-Admission Screening Authorization (DMAS-96).

FREEDOM OF CHOICE

For public pay individuals, the assessor or case manager, if applicable, **must** offer the individual the choice of service provider(s), including case managers and ALFs, that may be needed. When ongoing Medicaid-funded targeted ALF case management is needed, these choices must be documented on the Plan of Care. The individual's choice of providers is a federal requirement. Freedom of choice must be documented in the individual file of the recipient.

RIGHT OF APPEAL

Assessors must advise, orally and in writing, all applicants to and residents of ALFs for which assessment or targeted case management services are provided of the right to appeal the outcome of the assessment, the twelve-month reassessment, or determination of level of care. Auxiliary Grant applicants who are denied Auxiliary Grants because the assessor determines that they do not require the minimum level of services offered in the residential care level have the right to file an appeal with VDSS. A determination that the individual does not meet the criteria to receive assisted living services, intensive assisted living services, or Medicaid-funded ALF targeted case management services is an action that is appealable to DMAS.

FORMS REQUIRED FOR ADMISSION TO ASSISTED LIVING SERVICES

The assessor who is initiating a referral must call the provider first to notify him or her that the recipient has chosen his or her facility for services and to determine if the provider is able to initiate services promptly for the recipient. If the provider can accept the referral, the assessor will send the provider a complete packet required for the facility to admit the recipient to services.

If the provider does not receive an entire, thoroughly completed packet of referral forms from the assessor, as noted below, the provider must notify the responsible assessor and request the complete packet. A provider **will not** be reimbursed for services without the copy of the Long-Term Care Pre-Admission Screening Authorization (DMAS-96), completed by the assessor.

The forms that must be thoroughly completed by the assessor and forwarded to the ALF are:

- A full **Uniform Assessment Instrument** (UAI) completed by the assessor (the ALF will put a copy in the resident's record); and

- The **Long-Term Care Pre-Admission Screening Authorization** (DMAS-96) completed by the assessor (the ALF will put in the resident's record and send a copy to DMAS, along with a copy of the individualized service plan). The authorization must be completed for the appropriate level of care and must be signed and dated by the assessor prior to the start of services.

Assessors will make assisted living services referrals only to facilities that have met DMAS requirements and are enrolled under contract as a DMAS assisted living services provider.